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Instructions for Completion of CMS-1450 Billing Form

Key Words

MM3417, CR3417, CMS-1450, Billing Form

Provider Types Affected

All providers who bill Medicare Fiscal Intermediaries (FIs), including Regional Home Health Intermediaries (RHHIs)

Key Points

- The effective date for MM3417 is January 3, 2005. The implementation date is January 5, 2005.
- The National Uniform Billing Committee (NUBC) has approved the use of new value codes with an effective date of January 1. 2005.
- Key revisions to The Medicare Claims Processing Manual clarify the following Forms Locators (FL):
    - FL8 – Required for inpatient claims, non-covered days: Non-covered days include the days after the date of covered services ended such as non-covered level of care, or emergency services after the emergency has ended in a non-participating institution.
    - FL22 – Required for all Part A inpatient Skilled Nursing Facility (SNF), hospice, home health agency and outpatient hospital services: The patient status code indicates the patient's status as of the "Through" date of the billing period (FL6). The patient status code revisions follow:
        - Code 02 – modified to show that the patient was discharged/transferred to a short-term general hospital for inpatient care.
        - Code 05 – Indicated that the patient was discharged/transferred to a non-Medicare PPS children's hospital or non-Medicare PPS cancer hospital for inpatient care.

Note re: patient status code 05 – a Medicare distinct part/facility is exempt from the inpatient prospective payment system (e.g. children's hospitals and cancer hospitals).

- For a list of other distinct part units/facilities' specific patient status codes, (Codes, 62, 63, 65) please refer to MM3417, page 2.

- Code 43: relates to a discharge/transfer to a government operated health care facility. It is used when the destination of a discharge is a federal health care facility, whether or not the patient resides there.
- FL 24-30 – contain condition codes that apply to the relevant billing period:
  - Condition code 59 (effective October 1, 2004), non-primary ESRD facility – may be used. This indicates that an ESRD beneficiary received non-scheduled or emergency dialysis services at a facility other than his/her primary ESRD facility.
  - Condition code B4 – now used for an admission not related to a discharge on the same day, this code is for discharges on or after January 1, 2004, but not effective until January 1, 2005.
  - Condition code D4 – expanded for use in LTCHs, IRFs, and inpatient SNFs in addition to inpatient acute care hospitals.
- FL 39-41 – refers to value codes, two new codes will become effective January 1, 2005:
  - A8 – Weight of patient in kilograms
  - A9 – Height of patient in centimeters

Important Links

MM3417: Instructions for Completion of CMS-1450 Billing Form Revised: 10/15/2004

http://www.cms.hhs.gov/medlearn/matters/mmarticles/2005/MM3417_1.pdf